MRN: ____________________

Patient Name:______________________________ DOB:______________ Today's Date:______________

Financial Responsibility Notice and Consent Disclosure

Thank you for choosing Marietta Dermatology and The Skin Cancer Center. By signing this form you agree to a financial responsibility to provide payment in full for the services you've elected to receive from Marietta Dermatology and The Skin Cancer Center. These financial responsibilities include, but are not limited to, existing balances, your health insurance policy's deductible, coinsurance or copay, and any amounts or services that may be denied by your health insurance policy.

Financial Responsibility Policy:

By signing this form, I acknowledge and understand that any information provided to me by Marietta Dermatology and The Skin Cancer Center regarding my health insurance policy's benefits, referral or authorization requirements, or patient responsibility in the form of my deductible, coinsurance or copay is only a good faith estimate based on information provided by my health insurance carrier and is not a guarantee of approval or coverage for services I elect to receive; it is my responsibility to provide my current health insurance coverage information at the time of service; it is my responsibility to obtain any necessary referrals or authorizations and that failing to obtain any necessary referrals or authorizations may result in my visit being denied by my health insurance carrier; that any amounts quoted to me are not a guarantee of coverage or price and are subject to change based on the handling and processing of submitted claims to my health insurance carrier. _________(Please Initial)

It is the policy of Marietta Dermatology and The Skin Cancer Center that payment be made at the time of service to be applied to existing balances, deductibles, coinsurance, and/or copayment amounts. It is the policy of Marietta Dermatology and The Skin Cancer Center to collect $75.00 towards a high deductible policy whose deductible is not satisfied, a copay amount as specified by the insurance carrier, or the self-pay amount based on the services received. I understand I may be responsible for additional charges after my health insurance policy has received and processed the claim for my visit. _________ (Please Initial)

I have read and understand the above policy provided to me and I agree and accept the financial responsibility as described.

__________________________________   ___________________   ________________

Patient's Signature/Authorized Signature   Todays Date   Time

MRN: ______________

Marietta Dermatology and The Skin Cancer Center Patient Registration Information (PLEASE PRINT LEGIBLY)				
Last Name:	First Name, MI:	Preferred Name:	Date of Birth:	Gender:

Street Address:	City, State, Zip code:	Social Security #

Preferred Contact Method? Phone / Email	Mobile Phone# Ok to send Txt? ☐	Email Address:

Emergency Contact Name:	Emergency Contact #:

HIPAA PHI COMMUNICATIONS TO PATIENT. Please provide your consent to use your PHI for the following:

You may leave a detailed message on my answering machine or voicemail regarding my test results, other medical, or financial information. **YES / NO** (Please Circle)

Please list any persons whom our staff may discuss and/or disclose your health or financial information. If no individual is indicated below, our office is only able to communicate health and financial information with you, the patient.

NAME	RELATIONSHIP	PHONE NUMBER	PLEASE CIRCLE	
			Medical: YES / NO	**Financial: YES / NO**
			Medical: YES / NO	**Financial: YES / NO**

Patient Insurance Information (PLEASE PRINT LEGIBLY AND PROVIDE A COPY OF YOUR INSURANCE CARDS)			
Primary Insurance Company	Member ID (or ID#)	Group#	Relationship to Patient
Secondary Insurance Company	Member ID (or ID#)	Group#	Relationship to Patient
Tertiary Insurance Company	Member ID (or ID#)	Group#	Relationship to Patient

ACKNOWLEDGEMENT I acknowledge all information above is accurate

I authorize Marietta Dermatology Associates, P.A. (MDA) to release medical information to my insurance companies about treatment and diagnoses necessary to process claims. I authorize assignment of benefits, including Medicare, to be paid on my behalf to Marietta Dermatology Associates, P.A. for services rendered. I recognize that my insurance policy is a contract between my insurance company and me and that I am ultimately responsible for paying the claim(s) should my insurance company deny payment. By providing my email address I am aware that I may receive marketing material from this practice from time to time. I also consent to portal registration through Marietta Dermatology Associates.

If not covered by insurance, I understand that payment is expected at the time service is rendered, unless I made prior arrangements.

A photocopy of this shall be considered as valid as the original.

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	Date

MRN: ____________________

NO-SHOW & CANCELLATION POLICY

“No-Show” shall mean any patient who fails to arrive for a scheduled appointment. “Same Day Cancellation” shall mean any patient who cancels an appointment *less than* 24 hours prior to their scheduled appointment time.

A patient is notified of our “No-Show & Cancellation Policy” at the time of scheduling.

An appointment must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time.

Any patient who fails to show, cancels or reschedules an appointment less than 24 hours prior to their scheduled appointment time will be considered a No-Show and will be charged $25.00 (office visit) and $75.00 (procedures/surgery).

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office at 770-422-1013.

I have read and understand the Medical Appointment Cancellation/No-Show Policy and agree to its terms.

______________________________	______________________________
Signature (Patient/Legal Guardian)	Relationship to Patient
______________________________	______________________________
Print Name	Date

MRN:

Marietta Dermatology and The Skin Cancer Center - Patient Acknowledgements and Consent

CONSENT FOR TREATMENT: I consent to all diagnostic and treatment procedures/examinations provided at all offices of Marietta Dermatology and The Skin Cancer Center. This includes, but is not limited to, injections, biopsies, administration of medications, treatments, and procedures considered medically necessary for the care of my dermatologic condition. I understand that the procedures will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and prognosis before allowing procedures to be performed. I consent to treatment and care provided by a team of healthcare providers, which may include dermatologists, physician assistants, or advanced care practice nurse practitioners.

CONSENT FOR DISPOSAL OF HUMAN TISSUE: I agree that any tissues or specimens that are removed from my body while performing any procedures or providing my care and treatment will be examined and disposed of by Marietta Dermatology and The Skin Cancer Center.
In-House Dermatopathology Lab – I understand that Marietta Dermatology has an in-house pathology lab that my biopsies will be sent to and that my biopsies will be read by a certified Dermatopathologist. I understand that I may receive additional billing from Marietta Dermatology based on my deductible, coinsurance, or copay for lab services.

TELEPHONE CONSUMER PROTECTION ACT CONSENT: I expressly consent to receive telephone calls and text messages from Marietta Dermatology and The Skin Cancer Center, its affiliates, agents, vendors or third parties calling or texting on its or their behalf at any number that I provide, or that may be obtained, for contacting me. Such calls or texts may be made using an automatic telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose, including, but not limited to: communications about my treatment; medication assistance; insurance benefits or membership; appointment reminders; balance due and payment reminders; and debt collection attempts.

MEDICATION CONSENT: I provide consent to access and obtain a history of my medications purchased at pharmacies.

PHOTOGRAPHICS, VIDEOTAPES, AND RECORDINGS: I agree to turn off all recording devices prior to entering the exam room. I understand that physicians or staff may request to take photographs, videotapes, or other recordings of me for the purposes of ensuring proper patient identification, medical documentation, care, or treatment purposes. I understand the photograph(s) or videotape(s) will be used for documentation of my medical condition. I consent to being photographed, videotaped, or recorded for these purposes. I understand that such photographs, videotapes, recordings, and related information may be used for internal operations including, but not limited to, quality improvement activities and training programs that do not include treatment.

RETURN POLICY: I understand that skin care products and prescription pharmaceutical preparations are non-refundable.

TREATMENT GUARANTEE: I understand that there is **no** guarantee or warranty, expressed or implied by anyone, as to the results of any product, therapy, treatment, surgery, or service I may receive. I understand that any management of problems, complications, or follow ups may result in further financial responsibility beyond the initial visit.

PRIVACY PRACTICES: I acknowledge that I have been provided with a copy of the Notice of Privacy Practices from Marietta Dermatology and The Skin Cancer Center and that I have read, or had the opportunity to read, the notice.

Assignment of Benefits/Financial Agreements

ASSIGNMENT OF BENEFITS: If I am entitled to benefits under the Medicare program, or any insurance policy, or other health benefit plan, in consideration for services provided to me by Marietta Dermatology Associates, PA, dba, Marietta Dermatology and The Skin Cancer Center, I assign, transfer, and convey the benefits payable under such program, policy, or plan for services rendered to Marietta Dermatology and The Skin Cancer Center. I authorize payment of benefits directly to Marietta Dermatology and The Skin Cancer Center, with such benefits applied to my bill. I understand that the Assignment of Benefits does not relieve me of my financial responsibility for charges incurred, and I accept responsibility for and agree to pay charges not paid under this assignment, including, but not limited to, deductible, coinsurance, or services deemed non covered due to medical necessity or referral requirements. I agree to provide all known insurance information at the time of service. I authorize the application of any overpayment(s) to satisfy any outstanding charges I owe for services rendered.

INFORMATION RELEASE: I authorize Marietta Dermatology and The Skin Cancer Center to release all protected health information to my insurance and/or third-party collection agencies to secure payment for services rendered. I authorize the release of my medical information to my Primary Care Provider or Referring Provider for continuity of my care.

REFERRALS: I understand that I am solely responsible for obtaining any referrals or prior authorizations from my Primary Care Physician or Insurance Carrier for services I receive at Marietta Dermatology Associates and The Skin Cancer Center; that failing to do so may result in my visit being denied by insurance; that I am financially responsible for denied charges due to missing referrals or prior authorizations.

FINANCIAL RESPONSIBILITY POLICY: I understand Marietta Dermatology Associates and The Skin Cancer Center will collect $75 towards a high deductible policy whose deductible is not satisfied, a copay amount as specified by the insurance carrier, or the self-pay amount based on the services received at the time of service. I understand I may be responsible for additional charges after my health insurance carrier has received and processed the claim for my visit.

NO SHOW/CANCEL/RESCHEDULE POLICY: Any patient who fails to show, cancels, or reschedules an appointment less than 24 hours prior to appointment time will be charged the following: $25.00 fee - office visits; $75.00 fee - procedures/surgeries, no exceptions.

Signature of Patient or Parent/Guardian (if a minor) or Power of Attorney	**Relationship to Patient**: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Printed Name of Parent/Guardian or Power of Attorney, if applicable	**Date**:

MRN ________________

PATIENT INTAKE FORM

Patient Name______________________________ D.O.B:___________ Today's Date________________

PAST MEDICAL HISTORY:
Personal history of cancer other than skin cancer? ____

___Anxiety	___COPD	___High Blood Pressure	___Thyroid Issues
___Arthritis	___Depression	___Inflammatory Bowel Disease	___Radiation Treatment
___Asthma	___Diabetes	___Organ Transplant, Type_____	___Stroke
___Eczema	___Psoriasis	___Hay Fever	___Heart Disease

Other medical history not listed above:____

HISTORY OF SKIN DISEASE:
Personal History of Skin Cancer? ____ Basal Cell Carcinoma ____ Squamous Cell Carcinoma ___ Melanoma _____
Do you have a family history of melanoma? _______ Relative(s) with history: ______________________________

MEDICATION:
Check here if you have an attached list ______
Please include dosage and strength if known ____
____
____

Patient Height: ____________ Patient Weight: ____________ **(Required for Prescriptions)**
Allergies: ____

SOCIAL HISTORY: Do you smoke? Yes_____ No _____ Number of packs per day ____________

Do you drink alcohol? Yes_____ No _____ Number of drinks per week ____________

ALERTS:

___ Allergy to Adhesive	___ On Blood Thinners / Asprin	___ MRSA
___ Allergy to Lidocaine	___ History of Fever Blisters	___ Seizures
___ Allergy to Latex	___ Pacemaker	___ Kidney Disease
___ Allergy to Iodine	___ Defibrilator	___ C-Diff
___ Artificial Joint	___ HIV / AIDS	___ Pregnant or trying to be pregnant
___ Artificial Heart Valve	___ Hepatitis B	___ Breast Feeding
___ Allergy to Oral Antibiotics	___ Hepatitis C	___ Neurostimulator / Implantable Device
___ Requires Antibiotics Prior to Procedure	___ Rapid Heartbeat with Epinephrine	

PREFERRED PHARMACY:
Pharmacy Name:_____________________________ Pharmacy Number_________________________________
Pharmacy Address: ____
Primary Care Provider: ______________________________________ Referring Provider:____________________

I AUTHORIZE MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER TO RETRIEVE MY MEDICATION HISTORY THROUGH THEIR PRESCRIBING SYSTEM AND IMPORT IT INTO MY ELECTRONIC MEDICAL RECORD

SIGNATURE____ **DATE:**__________